TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CENTER

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-15-3024-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the facility was not paid for CPT 63661."

Amount in Dispute: $1,343.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 63661 is packaged into the APC rate."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2015	Procedure Code 63661	$1,343.55	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - MOPS – SERVICES REDUCED TO THE OUTPATIENT PERSPECTIVE PAYMENT SYSTEM (OPPS). (MOPS)
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)

- W3 –ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- MSIN – THIS IS A PACKAGED ITEM. SERVICES OR PROCEDURES INCLUDEDI NTHE APC RATE, BUT NOT PAID SEPARATELY. (MSIN)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P300 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT." Review of the submitted documentation finds no information to support that the disputed services are subject to a contracted fee arrangement between the parties to this dispute; reimbursement will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 84703 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Per Medicare's CCI Edit policy, procedure code 76000 may not be reported with procedure code 63688 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
   - Procedure code 63688 has a status indicator of Q2, which denotes T-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicator T that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. If no status indicator T codes have been billed and more than one separately payable T-packaged code is billed on the same date, the service with the highest reimbursement is paid at 100%. Reimbursement for all other packaged codes is considered included in the payment for the primary procedure. This procedure is the highest paying Q2 status service billed for this date. This service is paid at 100%. This procedure is classified under APC 0688, which, per OPPS Addendum A, has a payment rate of $2,128.81. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,277.29. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of $1,214.96. The non-labor related portion is 40% of the APC rate or $851.52. The

sum of the labor and non-labor related amounts is $2,066.48. The cost of these services does not exceed the annual fixed-dollar threshold of $2,775. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $2,066.48. This amount multiplied by the Division conversion factor of 200% yields a MAR of $4,132.96.

- Procedure code 63661 has a status indicator of Q2, which denotes T-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicator T that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 63688 billed on the same claim. Separate payment is not recommended.

4. The total recommended payment for the services in dispute is $4,132.96. This amount less the amount previously paid by the insurance carrier of $4,132.96 leaves an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	June 12, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.